ATTITUDES OF FAMILY THERAPISTS TOWARD THE TREATMENT OF ALCOHOLISM

A THESIS

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ABSTRACT

The present study was undertaken to explore the attitudes, interests, approaches, and success of family therapists in treating the alcoholic family, and to test three hypotheses.

A 52-item questionnaire was mailed to a systematic sample of members of the American Association for Marriage and Family Therapy, and the questionnaire was self-administered. The data collected from the questionnaires was analyzed by using central tendency; mean, range, median, and chi-square. The results of the study indicated a high agreement among the different professional groups; interest in treating the alcoholic family was neutral, as compared to treating other family problems.

Alcoholism is not simply an illness which incapacitates an individual. Alcoholism also affects the psychological, economic, social, and physical well-being of the family of the alcoholic, and the family can perpetuate the illness. This initial study examines how the family is affected by alcoholism and presents a rationale for looking to family therapy as a technique for treating and preventing alcoholism.

Literature is cited, and this research indicates the treatment advantages that accrue from working with families. As indicated in this research, family therapy techniques and family therapists have been more successful in treating alcoholism than the national expectancy.

Finally, despite the apparent advantages gained from the application of family systems therapy, the treatment of alcoholic families in practice remains limited; the attitudes toward prognosis for recovery are generally negative, and the treatment of alcoholism is seen as unrewarding.

CHAPTER I

INTRODUCTION

The purpose of this thesis is to review alcoholism, the effects of alcoholism on the family, family therapy with alcoholic families, and attitudes of psychotherapists toward treating alcoholism. A secondary goal is to explore the variables related to treating alcoholism as viewed by family therapists.

Alcoholism is not simply an illness which disables an individual. Alcoholism also affects the emotional, economic, social, and physical well-being of the family of the alcoholic. Alcoholism has been called the "family illness" because of its damaging impact upon the entire family system. Family members as well as the alcoholic person himself experience the piercingly painful effects of the progressive destruction associated with this serious and prevalent disorder.[1]

Previously, alcoholics were conceptualized as homeless and jobless individuals who had meager psychological resources and were physically ravaged as well. The lonely alcoholic sitting at the end of a public bar, a rich Madison Avenue socialite forgotten in her plush but empty apartment,

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[1] Nada J. Estes, "Counseling the Wife of an Alcoholic Spouse," American Journal of Nursing 74 (1974):1251.

or the shabbily clad drunk shivering on a park bench, all seem to be alone and by themselves. But this frequently seen isolation and desertion by family, colleagues, and friends occurs after a long history of drinking episodes and interactions with others which have produced guilt, anger, hostility, and alienation.[2] At this time it is clear that the "end stage" alcoholic is not representative of the population that abuses alcohol.[3] A significant number of alcoholics, if not the majority, continue to function within intact family systems.[4]

While most persons who use beverage alcohol usually do so without harm to themselves or others, a sizable minority --an estimated 10 million Americans including 3 million women, 500,000 children, and 1.6 million elderly--are alcoholics (as presented by the January 1981 fact sheet on alcoholism from the Department of Human Resources). Also, from this same report, in Georgia there are an estimated 265,000 alcoholics and persons with serious drinking

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[2] Shirley A. Smoyak, "Therapeutic Approaches to Alcoholism Based on Systems Theories," Occupational Health Nursing 21 (1973):27.

[3] Peter Steinglass, "Experimenting with Family Treatment Approaches to Alcoholism, 1950-1975: A Review," Family Process 15 (1976):97.

[4] Ibid.

problems. Based on national figures, an estimated 100,000 of these are women, and 45,000 are teenagers between the ages of 13 and 19. Because alcoholism affects the entire family, 1,060 persons, including spouses and children, or 20 percent of Georgia's population, is affected. According to a 1977 Gallup Poll, 18 percent of Americans found liquor to be a cause of trouble in their families, and approximately 41 percent of the marriages of alcoholics are considered unstable.[5] There is a higher rate of parental separation reported for alcoholic families in comparison to families in which drinking is not a problem.[6] The family of an alcoholic has an increased likelihood of being disrupted due to incapacitation of the alcoholic member or an accident related to the drinking. From 40 to 60 percent of all homicide victims and up to 86 percent of offenders have been related to alcohol abuse according to the January 1981 report on alcoholism from the Department of Human Resources.

Children are at particularly high risk with regard to the destructive effects of alcoholism, and research has shown that, due to their disrupted family life, children of alcoholics can and do suffer seriously damaging

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[5] Kevin Kenward and Jean Rissover, "A Family Systems Approach to the Treatment and Prevention of Alcoholism: A Review," Family Therapy 7 (1980):97.

[6] Joan McCord, "Etiological Factors in Alcoholism, Family and Personal Characteristics," Quarterly Journal of the Studies of Alcohol 33 (1972):1022.

developmental effects. There is a 35 percent greater chance of serious emotional disturbance in children when one parent is an alcoholic, and this increases significantly if both parents are abusers.[7] Also, if one parent is an alcoholic there is a six times greater chance that the children will have an alcohol problem.[8] And a stream of reports from both scientific and government sources have called attention to the fact that once again alcohol is the drug of choice for the American teenager.

Parental alcoholism has been established as a contributing factor to child abuse and neglect. According to the American Humane Association, alcohol dependence was a factor in 17 percent of the families in which child abuse or neglect occurred, and alcohol played a role in about one-third of all cases of child abuse.[9]

Scientists have indicated in recent studies that heavy maternal alcohol consumption during pregnancy can result in Fetal Alcohol Syndrome, a disorder characterized by patterns

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[7] Frederick Watts and Bennie Bowen, Conjoint Family Counseling for Substance Abuse Counselors 3 (1978):88.

[8] Ibid.

[9] Kenward and Rissover, "A Family Systems Approach," p. 99.

of physical, mental, and behavioral abnormalities.[10] One out of three infants born to women who drink heavily is reported to have abnormalities such as physical handicaps or mental retardation.[11]

I believe it is safe to assume that we have a major health problem in epidemic proportions, which affects not only individuals but families.

Not only does alcoholism affect the entire family; frequently the family may contribute to that behavior, and the problems associated with alcoholism may be perpetuated by non-drinking as well as drinking members of family groups.

> Alcoholism, like drug addiction and schizophrenia, is best seen as a form of family interaction in which one person is assigned the role of the "alcoholic" while others play the complementary roles, such as the martyred wife, the neglected children, the disgraced parents, and so forth. As this deadly game is played by mutual consent, any attempt to remove the key actor, the alcoholic, is bound to create difficulties for the other members, who will attempt to restore their former game.[12]

Family therapists view alcoholism as a dysfunction within the family; the family system and not the individual alcoholic is seen as the client. Bowen asserts that a

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[10] U. S. Department of Health, Education and Welfare, National Institute on Alcohol Abuse and Alcoholism, "Alcohol and Your Unborn Baby" (Washington, D. C.: Government Printing Office, 1978), p. 3.

[11] Ibid.

[12] James C. Coleman, Abnormal Psychology and Modern Life (Illinois: Scott, Foresman and Co., 1976), p. 247.

change in the functioning of one family member is automatically followed by a compensatory change in another family member.[13] In other words, the dysfunction of one family member is reacted to by the over-function of another family member in order to maintain a sense of balance or homeostasis.[14]

The fact that alcoholics live with or are in significant contact with related others, the effects of alcoholism on the family, and the important role that family interactional processes seem to play in maintaining alcohol abuse behavior in an individual are some dimensions of the rationale for looking to family therapy as a technique for treating alcoholism.

Steinglass points out that although alcohol specialists have found family therapy techniques extremely useful in their work, family therapists have shown little interest in the clinical and theoretical aspects of alcoholism.[15]

My intention in this research paper is to explore: (1) possible reasons for this disinterest and (2) the possible reasons for the lack of emphasis on including whole families in the process of treating alcoholism. This

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[13] Murray Bowen, "Alcoholism and the Family," in Family Therapy in Clinical Practice (New York: Jason Anderson, Inc., 1978), p. 263.

[14] Ibid.

[15] Steinglass, "Experimenting with Family Treatment," p. 116.

study will attempt to close the gaps indicated above by: (1) surveying family therapists who work with families on an ongoing basis and (2) comparing the significant variables related to treating alcoholic families.

CHAPTER II

REVIEW OF THE LITERATURE

The recent increase in process research has resulted in more direct examination of what is important in family therapy with alcoholic families. Relevant research falls into three categories: (1) alcoholic families; (2) family therapy theoretical approaches; and (3) attitudes toward alcoholism.

Alcoholic Families

Alcoholic families include such characteristics as personality of family members, familial alcohol abuse, effects which alcohol has on the family, and the function which alcohol carries out in the family interaction.

The pathology of the family itself has long been suspected as a causal factor in some cases of alcoholism. As it was put by one center treatment director for alcoholism, "Sometimes the non-alcoholic spouse needs the alcoholic to be sick. Sometimes they may even be setting them up for their next drunk."[1] Conversely, the family members may unwittingly be encouraging drinking behavior, and the alcoholic may be enabled by an unhealthy family climate. Or

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[1] "Alcoholism and the Family: Putting the Pieces Together," Alcoholism: The National Magazine 1 (January/February 1981):20.

the alcoholic may be what has been called "defiantly dependent," reaching out to the family for help with the right hand while defensively rejecting all help with the left.[2]

If the subject of the alcoholic is considered controversial, the subject of the alcoholic's spouse is even more controversial. Even though viewing alcoholism through a family systems approach sees the spouse not as a villain but as a part of the overall functioning of the family system, there are certain personality types that have been researched in connection with the spouse of the alcoholic.

Research during the past 40 years on the wives of alcoholics has attempted to assess two major propositions. One is that women with certain types of personalities tend to select alcoholics or potential alcoholics as mates in order to satisfy unconscious needs of their own, and that these needs foster the continued drinking of the husband.[3] A second proposition is that women experiencing stress as a result of living with an alcoholic spouse will manifest neurotic traits and psychosocial disturbances.[4] It was also suggested in a similar fashion that the wife of an

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[2] Ibid.

[3] Theodore Jacob et al., "The Alcoholic's Spouse, Children and Family Interaction," Journal of Studies on Alcohol 39 (1978):1232.

[4] Ibid.

alcoholic is a person with severe, longstanding psychopathology antedating marriage, which led her to choose an alcoholic husband as a way of satisfying and stabilizing intrapsychic needs.[5]

Notwithstanding the conservative estimate of 3 million women alcoholics in the United States, few well controlled studies of husbands of alcoholics were found, and the information was conflicting. In one report women alcoholics were seen as having a tendency to marry domineering husbands;[6] while in another report it was suggested that the husbands of women alcoholics have feminine and passive personalities and are emotionally inaccessible, less sociable, and introverted.[7]

There have been many different scripts related to alcoholism and labeling of the characters and the parts they play in the marriage. Steiner presented a dyadic pair involved in an alcoholic game which he named "Lush." The game is most often played by middle-aged suburban housewives or aging male homosexuals, and is played in response

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[5] Steinglass, "Experimenting with Family Treatment," p. 99.

[6] Jacob et al., "The Alcoholic's Spouse, Children and Family," p. 1233.

[7] Daniel Dinsbury et al., "Marital Therapy of Women Alcoholics," Journal of Studies on Alcohol 38 (1977):1255.

to sexual deprivation. Lush cannot get affection from her/his partner under normal circumstances, so settles for the costly attention that he/she receives when rescued. Lush characteristically drinks at home and says to husband, "I'm unable to control my drinking." The husband says: "I will help you control yourself" (Rescuer); or "You're a liar" (Persecutor); or "I know what you mean, have another one" (Patsy).[8] In such marriages where there is an obsessional and hysterical personality, the central difficulty is thought to be that of intimacy.

A personality trait seen in both male and female alcoholics is a gregarious facade and often a deep-seated and feared introversiveness. Their self-esteem is easily threatened, and when it is they feel hostile, which often leaves them feeling tense and anxious in social situations. Many alcoholics are confused about their affectional needs; they want affection, have difficulty when affection is offered, and interpret these feelings as additional evidence of underlying inadequacy.[9]

From these ideas, therapists begin to think of what contributions each individual brings to a relationship and the possible selective processes for choosing a spouse.

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[8] Claude Steiner, Games Alcoholics Play (New York: Ballantine Books, 1971), p. 92.

[9] Donald A. Cadogan, "Marital Group Therapy in Alcoholism Treatment," in Family Therapy of Drug and Alcohol Abuse (New York: Garden Press, 1979), p. 191.

Bowen has emphasized the concept of differentiation of the self, which he defines as the "degree to which the person has a 'solid self' or solidly held principles by which he lives his life."[10] The degree to which any individual is differentiated is related to the level of differentiation of his or her parents, his or her relationship with them, and how the individual has handled unresolved attachments to the parents in his own adult life. An individual can seldom reach a level of differentiation much higher than that of his parents. Marriage involves the establishment of a relationship between two individuals who have usually selected a mate at a level of differentiation similar to their own. The level of differentiation of the parents predicts the overall degree of differentiation in the new family. Therefore, in a family with a low level of differentiation, the family members lacking the "solid self" to which Bowen refers would frequently ascribe their own characteristics or feelings to other members of the family, as seen in the alcoholic family.[11]

A view of how alcoholism functions in the family can be seen from the idea of homeostasis. Any system that is exposed to stresses and various external pressures will at

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[10] Murray Bowen, "Alcoholism as Viewed Through Family Systems Theory and Family Psychotherapy," Annals of the New York Academy of Sciences 233 (1974):117.

[11] Ibid., p. 118.

some point introduce change into the system. Systems theory suggests that all family systems operate to maintain a certain level of equilibrium, which is intended to "minimize the threats of disruption and pain."[12] This equilibrium is established in order to maintain the family unit. Therefore, any attempts to introduce change into the system will lead to resistance or compensatory changes within the system. For example, if one member is an alcoholic and is functioning at a reduced level, there would be automatic compensation by the family so that other members of the family would assume additional functions and responsibilities for that period of time.[13]

The most striking example of homeostasis noted by family therapists treating alcoholic families is: "It has been frequently observed that, in response to the treatment of a single family member other members tried to sabotage, or become a part of his treatment as though they had a stake in his/her illness."[14]

One does not become an alcoholic alone. Increasingly, it is becoming clear how one person's addiction affects the family's coping mechanisms, and how the family's response

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[12] D. E. Meeks and C. Kelly, "Family Therapy With the Families of Recovering Alcoholics," Quarterly Journal of Studies on Alcohol 31 (1970):400.

[13] Ibid.

[14] Ibid., p. 399.

influences the progression of the dependency. From a structural point of view, an alcoholic is not just an orally dependent person nor one who uses alcohol as a symbolic way of communicating, but a person who is embedded in a structure which both influences and is influenced by his drinking.[15]

"Alcoholism is dominoes. The alcohol knocks down the alcoholic who knocks down everyone else, including themselves."[16]

In an alcoholic's life, there is no such thing as an innocent bystander. Everyone with whom he or she comes in contact is involved, like it or not. This truism applies with vengeance when it comes to children of alcoholics and growing up with one or both parents being an alcoholic. Research findings indicate that these children are a high-risk population and are the principals in a hidden tragedy. Alcoholism is a familial disorder, and studies have repeatedly shown a high incidence of alcoholism and other psychopathology among relatives of alcoholics, children being in

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[15] Vincent D. Foley, "Alcoholism: A Family System Approach," Journal of Family Counseling 4 (December 1976): 4.

[16] Claudia Black, "Innocent Bystanders at Risk: The Children of Alcoholics," Alcoholism: The National Magazine 1 (January/February 1981):22.

a particularly vulnerable position.[17] The most current findings indicate that these children are the most likely to either marry an alcoholic, become an alcoholic themselves, marry other high-risk people, or develop chronic patterns of emotional instability.[18] All these phenomena can be traced to both environmental and psychological influences and genetic factors.[19] In addition to being affected through genetic transmission, the child grows up in an environment disrupted by alcoholism. Frequent arguments, separation, divorces, emotional disturbances and financial difficulties are characteristics found in the alcoholic family.[20] Also, the emotional and behavioral disorders of the children are not hard to understand, since life in the home of an alcoholic parent can be chaotic, confusing, and unpredictable, and frequently involves parental neglect and even physical abuse of the children.[21]

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[17] Barbara M. Herjanic et al., "Children of Alcoholics," Currents in Alcoholism: Psychiatric, Psychological, Social and Epidemiological Studies (New York: Grune and Stratton, Inc., 1977), p. 445.

[18] Black, "Innocent Bystanders," p. 22

[19] Ibid.

[20] Herjanic et al., "Children of Alcoholics," p. 446.

[21] Margaret Hindman, "Children of Alcoholic Parents," Alcohol Health and Research World (Winter 1975/76), p. 2.

The most current and reliable estimates indicate that there are somewhere between 28 and 34 million people in the United States who are being reared or have been reared in an alcoholic home; of this total, about 12 to 15 million under 18 are currently living in a home with at least one alcoholic parent.[22]

Looking more closely at the effects of parental alcoholism, it has been found that children of alcoholic parents have fewer peer relationships and show a greater trend toward maladjustment than their peers from nonalcoholic homes; adolescents seem to be the most vulnerable to this maladaptive behavior.[23] The behavior of the alcoholic parent, and often that of the nonalcoholic spouse as well, tends to be erratic and inconsistent. Alcoholism is the focus of family life, and the children are often ignored or neglected, disciplined inconsistently, and given few concrete limits and guidelines for behavior.[24] Contributing also to the emotional problems, the family is generally isolated from other members of the community. Due to the alcohol problem, there are few group activities at home and few family outings.[25] Friendships too are often avoided by

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[22] Black, "Innocent Bystanders," p. 22.

[23] Hindman, "Children of Alcoholic Parents," p. 3.

[24] Ibid.

[25] Ibid.

both the nonalcoholic spouse and the children because they are ashamed of alcoholism in their family.

As Margaret Cork, author of The Forgotten Children, quotes the child of an alcoholic parent:

> Mostly I'm by myself--there isn't anyone I really know. We've moved a lot and I don't want to make new friends. Even if I had a friend, I wouldn't bring him home. I wouldn't want him to know what my family is like. I'm afraid he'd hear the fighting or see my dad, and then he wouldn't like me. Mom says we shouldn't tell anyone (about dad's alcoholism). Anyway, I'd hate for them to know. I'm too ashamed. . . . People shouldn't know your business. I wouldn't want them to feel sorry for me.[26]

A poor self-concept, which has been observed in alcoholic persons as well as in their children, is considered to be a primary trait of persons who engage in self-destructive behavior and isolation. Dr. Ruth Fox writes:

> When children become aware of the social stigma surrounding alcoholism, they feel different, estranged, isolated, and ashamed, and often do not wish to go out as a family; this isolation further intensifies their already low self-esteem confirming their inner sense of worthlessness.[27]

In addition to the social and psychological deprivation which the children of alcoholics experience, there is also the threat of child abuse and neglect. Drinking is very likely connected to child abuse and neglect, including sexual abuse. Situational factors which have been

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[26] Ibid., p. 1.

[27] Ruth Fox, "The Effects of Alcoholism on Children," National Council on Alcoholism (1972), p. 3.

associated with child abuse and neglect are: a parental history of abuse or neglect as a child; chronic illness and unemployment; stressful life circumstances including poverty; social isolation and associated lack of support; youth and associated inexperience; unwanted pregnancy; and absence of one parent.[28] As is apparent, many families in which one or both parents are alcoholics experience one or more of these situational factors. Studies of child abuse and neglect implicate alcoholism, in some areas, in as many as 90 percent of the reported cases.[29]

Certain characteristics of children which detract from their acceptability or their responsiveness to the parent have been identified, in addition to the role of situational and personality factors, in child abuse and neglect. Some of these factors are mental retardation, deformity, illness, behavioral problems including hyperactivity, disobedience, delinquency, and emotional difficulties including withdrawal and lack of responsiveness.[30] The child of an alcoholic is affected both before and after birth. The

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[28] Joseph Mayer and Rebecca Black, "The Relationship Between Alcoholism and Child Abuse and Neglect," Currents in Alcoholism: Psychiatric, Psychological, Social and Epidemiological Studies 2 (New York: Grune and Stratton, Inc., 1977):433.

[29] Ibid., p. 435

[30] Ibid., p. 434.

child born into an alcoholic family is likely to experience the psychological traumas resulting in behavioral changes, therefore his lack of acceptability; and the infant may suffer from Fetal Alcohol Syndrome, producing physical, mental, and behavioral abnormalities--which also places them as likely candidates for physical abuse.

The most shocking piece of literature thus far in this review has to be a pamphlet put out by The National Foundation/March of Dimes: "If you drink, your unborn baby does too!" In 1973, a common pattern of dysmorphology in children born to alcoholic mothers was described by K. I. Jones and D. W. Smith, and the constellation of the defects was named Fetal Alcohol Syndrome (FAS).[31]

These initial reports have triggered a voluminous body of literature in the last five years that span nearly all fields of science from teratology to neurology, and most recently include Fetal Alcohol Syndrome as a family affair. Fetal Alcohol Syndrome is the clinical occurrence of: (1) characteristic craniofacial peculiarities; (2) prenatal and postnatal growth disturbances; and (3) mental insufficiency.[32] Although much remains to be discovered,

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[31] Carrie Randall, "Introduction to Fetal Alcohol Syndrome," Currents in Alcoholism: Biomedical Issues and Clinical Effects of Alcoholism 5 (New York: Grune and Stratton, inc., 1979):119.

[32] Ibid.

it is now almost certain that alcohol crosses the blood-brain and placental barriers of the fetus in approximately the same concentration as that found in the mother.[33] Studies from the University of Washington suggested that as little as one to two ounces of absolute alcohol per day may adversely affect the fetus, and binge drinking may also be harmful.[34] The National Institute of Alcohol Abuse and Alcoholism issued a more conservative statement claiming that six mixed drinks per day will certainly have adverse effects on the fetus and that even three drinks per day will produce some features of FAS.[35] The impact of less than three drinks a day is not clear, and the FDA recommends no more than two drinks per day.[36]

Alcohol interferes with the absorption and the utilization of nutrients and with protein synthesis. Heavy alcohol consumption is most likely to affect fetal structure during the first trimester, when organogenesis is taking

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[33] Gilbert E. Corrigan, "The Fetal Alcohol Syndrome," Texas Medicine 72 (1976):72.

[34] Randall, "Introduction to Fetal Alcohol Syndrome," p. 119.

[35] Ibid., p. 120.

[36] Ibid.

place.[37] When there is an increase in cell size rather than in cell number, during the second trimester, poor diet and heavy alcohol consumption are apt to affect the infant's weight.[38] Also, because women who chronically drink may be malnourished, even a decrease in alcohol intake just before conception may leave her body depleted of vitamins and protein reserves.

This congenital disorder is 100 percent preventable; no FAS babies have been born to mothers that don't drink alcohol.

Family Therapy Theoretical Approaches

A project was instituted in the outpatient department of the Henry Phipps Psychiatric Clinic at Johns Hopkins Hospital in 1974 involving concurrent group meetings of the male alcoholics and their wives. This project represented the first attempt to adapt group therapy, the most successful psychological therapy approach to alcoholism, to a family orientation.[39] This study was a pivotal one in the development of family techniques for the treatment of alcoholism.

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[37] Barbara Luke, "Maternal Alcoholism and Fetal Alcohol Syndrome," American Journal of Nursing 77 (December 1977):1925.

[38] Ibid.

[39] Steinglass, "Experimenting with Family Treatment," pp. 100-101.

The first union of family theory and alcoholism therapy was seen in Ewing and Fox's article in 1968, "Family Therapy of Alcoholism."[40] In this article, they adapted the theoretical concept of homeostasis in family systems. The alcoholic marriage was viewed as a "homeostatic mechanism" that is

> established . . . to resist change over long periods of time. The behavior of each spouse is rigidly controlled by the other, and as a result, an effort by one person to alter his typical role of behavior threatens the family equilibrium and provokes renewed efforts by the spouse to maintain the status quo.[41]

From their experiences with marriages of alcoholics, Ewing and Fox suggested that no longer can alcoholism be seen purely in terms of intrapsychic dynamics; that the alcoholic's insight is frequently insufficient unless he is able to withstand his wife's resistance to his change and to help her find other outlets for her protective needs.[42] Also, they had seen that the wives of alcoholics they had treated showed a marked resemblance to each other, and it was believed that appreciation of their own dependency needs and acceptance of some responsibility for the husband's drinking must accompany real changes in their

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[40] John A. Ewing and Ronald E. Fox, "Family Therapy of Alcoholism," Current Psychiatric Therapies 8 (New York: Grune and Stratton, Inc., 1968):86.

[41] Ibid., p. 87.

[42] Ibid., p. 91.

marital roles if the alcoholism dynamics were to cease.[43] "It is the family's emotional homeostasis which seems to perpetuate the drinking and it is this behavior which must be changed if the drinking is to be controlled."[44]

It was in the late 60's and early 70's that family dynamics began to formulate a theory base that viewed the family as the primary recipient of treatment. The major work that began conceptualizing family therapy was Virginia Satir's Conjoint Family Therapy. This book was the first major work to see the family system itself as being a dynamic body. In Satir's work, the primary focus is not on one individual dysfunction but on the interplay of family dysfunctions.[45] The family systems concept is based on the principle that a therapist can treat a person in an office, hospital, halfway facility, etc., but that the individual will be spending most of his/her time within the family environment and that this family has a significant impact on the treated person's behavior. Family systems therapy also holds as a basic principle that emotional pain or dysfunctioning cannot not be felt by the entire family. The pain that the family identifies is a symptom of the underlying dysfunctioning of the entire family unit and significantly

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[43] Ibid.

[44] Ibid.

[45] Virginia Satir, Conjoint Family Therapy (Palo Alto, California: Science and Behavior Books, Inc., 1967).

relates to the marital dyad. Family systems theory sees the marital dyad as the emotional core of the family. As Satir puts it, they are the "architects."[46] Satir's focus is on interaction, communication, role performance, and redefinition of problems in the family rather than in individual terms.[47]

Bowen also views alcoholism as potentially explainable in the language of family systems theory:

> Systems theory assumes that all important people in the family unit play a part in the way family members function in relation to each other and in the way the symptom finally erupts. The part that each person plays comes about by each "being himself."[48]

By looking at alcoholism through the principles of family systems theory, it can be conceptualized as a symptom of the larger family or social unit. From Bowen's experience, alcoholism occurs when the family anxiety is high, and the excessive drinking stirs even higher anxiety in those dependent on the one who drinks.[49] As the anxiety increases, the more other family members react by anxiously doing more of what they are already doing. The circular process of drinking to relieve anxiety, increased family

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[46] Ibid., p. 101

[47] Ibid., p. 73

[48] Bowen, "Alcoholism and the Family," p. 259.

[49] Ibid.

anxiety in response to drinking, can continue until it becomes chronic or until there is a functional collapse.[50]

A family is a system in that a change in the functioning of one family member creates a compensatory change in another family member to maintain the familiar levels of functioning. Therefore, to understand individual behavior, it is essential to understand the significant group in which a person lives, the relationships with that group, and the importance of any particular individual's behavior to maintaining the system. The system is considered to have properties beyond those of the individual members and is more than the behaviors and personalities of the individuals in the system; "the whole is greater than the sum of its parts."[51] Therefore, in therapy the target for change is the whole system and not the individual.

With systems theory, as opposed to intrapsychic theory, the focus is on observable facts of the relationships. Family systems theories are interested in tracking behavior, what happens in family interactions, how it came about, when the behavior occurred, in what relation to other family interactions, and where the incidents occurred.[52]

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[50] Ibid.

[51] Thomas J. Paolino, Jr. and Barbara S. McGrady, "Systems Theory Approaches to the Alcoholic Marriage," in The Alcoholic Marriage (New York: Grune and Stratton, Inc., 1977), p. 111.

[52] Ibid.

A metaphorical description of the family system was presented by Sharon Loepscheider:

> A family system resembles a mobile. A mobile is an art form made up of rods and strings upon which are hung various parts. The beauty of the mobile is in the balance and its flexibility. The mobile has a way of responding to changing circumstances such as the wind. It changes position, but always maintains connection with each part. If one flicks one of the suspended parts, energy, the whole system moves to gradually bring itself to equilibrium. The same thing is true of a family. In a family where there is stress, the whole organism shifts to bring balance, stability and survival.[53]

In the alcoholic family, each of these individual parts become affected by the growing dysfunction of the chronically dependent person. Family members begin slowly to adapt to the behavior which causes the least amount of personal stress. The alcoholic is suffering from self-delusion in regard to the uses of the chemical, and so are the family members self-deluded.[54] As the alcoholic progresses and his illness becomes chronic, each member of the family begins to repress their feelings and to react to survive in the situation. This behavior serves to build a wall to protect all members from the pain.

Looking at treatment modalities, Bowen has warned about the problems of falling into cause-and-effect thinking

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[53] Sharon Loepscheider, "From the Family Trap to Family Freedom," Alcoholism (January/February 1981), pp. 36-37.

[54] Ibid., p. 37.

in doing family therapy.[55] In the field of alcoholism, many people are still looking for ultimate causes, trying to find out if alcoholism is a biological addiction, if alcoholics are orally dependent people, if the spouse of an alcoholic causes the alcoholism, or if alcoholism is caused by basic disturbances in our society. At the same time that the therapist recognizes that there is no ultimate cause of alcoholism, he also needs to recognize that there are factors that contribute to an alcoholic drinking pattern, and that these factors operate at different levels. For example, if an individual drinks a quart of whiskey every day, he will likely become biologically addicted to alcohol. If an individual comes from a family where there are alcoholics, he is either likely to become an alcoholic himself or marry someone who is alcoholic.[56] Also, if someone lives in a society where alcohol is important, such as the suburban housewife who drinks to pass the time, the businessman who has a two-martini lunch, or the inner-city unemployed man, they are all at risk of becoming alcoholic.

All factors are important; the contributions of the biological, psychological, family and social level all might be factors toward producing an alcoholic individual

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[55] Bowen, "Alcoholism and the Family," p. 261

[56] Black, "Innocent Bystanders," p. 22.

or alcoholic family system, but none of these alone can be said to cause alcoholism.[57] With this consideration, in doing family therapy it may be first necessary to biologically detoxify the alcoholic, deal with family systems issues within both the nuclear and extended family, and finally to help both the spouse and the alcoholic with social problems.[58]

There are several phases of the treatment of alcoholism. Systems theory provides a way of conceptualizing the part that each member plays. Using this theory, the therapy is directed at helping family members with the most resourcefulness, who have the most potential for modifying their own functioning.[59] The main leverage in a system where one spouse drinks excessively is the nondrinking spouse. He or she is usually the one who is suffering more and is more motivated to make a change.

Berenson has described many different approaches to treating the family, from seeing only the spouse of the alcoholic, seeing the oldest daughter of a mother who was an alcoholic, to seeing the couple, nuclear and extended family.[60] When it is possible to modify the family

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[57] David Berenson, "Alcohol and the Family System," in Family Therapy (New York: Garden Press, Inc., 1976), p. 285.

[58] Ibid., p. 286.

[59] Bowen, "Alcoholism and the Family," p. 262.

[60] Berenson, "Alcoholism and the Family System," p. 289.

relationship system, the alcoholic dysfunction is alleviated, even though the dysfunctional one may not have been part of the therapy.

It is often necessary to get a complete drinking history and to let the family define alcohol as the problem, but the family therapist does not label it the problem. The first phase includes getting the family system "calmed down" and the drinking stopped. The second phase is to establish intimate behaviors by the couple that were previously only expressible in extreme form while one or both partners were drinking.[61] It is also felt that a wholistic approach is beneficial with the use of Alcoholics Anonymous (AA) for the alcoholic and referring the spouse to Al-Anon, which is an indigenous self-help family group modeled after AA. In Al-Anon the peers are spouses, children and close relatives of alcoholics.[62] Also, it is important to include the children in Alateen, a supportive group for the children of alcoholics that includes education and prevention.[63] Both in Al-Anon and Alateen, the family members receive emotional support and practical tips. Also, referring the couples to

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[61] Ibid., p. 291.

[62] Peter Steinglass, "Family Therapy with Alcoholics," in Family Therapy of Drug and Alcohol Abuse (New York: Garden Press, Inc., 1975.

[63] "Understanding Alcoholism," in Alateen, Hope for Children of Alcoholics (New York: Al-Anon Family Group Headquarters, Inc., 1973), p. 3.

multiple-couples groups where some supportive network can be created, or to more specialized groups such as sex therapy and transcendental meditation, has been a positive contribution to the overall successful treatment of alcoholism.[64]

Attitudes Toward Alcoholism

A review of the literature has not revealed any scientific research studies on the attitudes of family therapists in the treatment of alcoholism. However, there has been research documented on the attitudes of other professionals and paraprofessionals who have worked with alcoholics, and the effects of these attitudes.

The role of physician attitudes in determining both the quality and quantity of health care for alcoholics has been a crucial factor in determining medical treatment. Studies of diagnostic practices indicate that the typical position physicians take is that it's better to suspect an illness than not, except in the case of alcoholism where it seems safest not to diagnose alcoholism until clear signs of intoxication or withdrawal are present.[65] It has also been noted that diagnosis may be delayed or missed and that many physicians have a stereotype of the alcohol-

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[64] Berenson, "Alcohol and the Family System," p. 292.

[65] John N. Chappel, "Physician Attitudes and the Treatment of Alcohol and Drug Dependent Patients," Journal of Psychedelic Drugs 10 (January/March 1978):27.

dependent patient as a "derelict" and rely on physical symptoms to make their diagnosis.[66] It was also stated that negative attitudes toward alcoholism are often taught indirectly in medical schools, where there is an increase of negative attitudes from medical students to house staff.[67]

In a study done in 1971, it was found that psychiatrists and psychologists recommended hospital treatment for alcohol dependence even though they were pessimistic about the outcome and few were willing to be involved in treatment.[68] Physician pessimism about treatment outcomes has the effect of a self-fulfilling prophecy; and therapist expectations about outcome have a significant effect on the results of psychotherapy.[69]

Waring, in 1975, wrote of the vigorous efforts being made to change the longstanding, stereotyped attitudes of professionals and the lay public toward the misuse of alcohol. She found few professionals interested in treating alcoholics or working in addictive disease facilities even after the Comprehensive Alcohol Abuse and Alcoholism

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[66] Ibid.

[67] Ibid.

[68] W. J. Know, "Attitudes of Psychiatrists and Psychologists toward Alcoholism," American Journal of Psychiatry 127 (November 1971):1676.

[69] Ibid.

Act in 1970.[70] She found a variety of reasons for this: most professionals still view alcoholism as hopeless and alcoholics as weak-willed and dependent; still others who diagnose the problem in middle- and late-stage alcoholism fail to take action because they view the alcoholic as unmotivated or hard to reach; and professionals often lack knowledge about alcoholism and what services are available.[71]

In a study examining the effect of the medical school experience on physicians' attitudes toward alcoholic patients, it was found that some of the negative attitudes could be attributed to the frustrating results in treating alcoholics, and failure to effect a change in the patient's drinking behavior.[72] It is interesting to note that the conclusion of this study indicated that there was not sufficient cognitive training in medical schools on alcoholism.[73]

Alcoholics are often perceived to be among the most undesirable candidates for psychotherapy. Not only do they evoke feelings of helplessness and hopelessness in many

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[70] Mary L. Waring, "The Impact of Specialized Training in Alcoholism on Management-Level Professionals," Journal of Studies on Alcohol 36 (1975):406.

[71] Ibid., p. 407.

[72] Joseph C. Fisher et al., "Physicians and Alcoholics," Journal of Studies on Alcohol 36 (1975):953.

[73] Ibid., p. 954.

therapists, but they also may conjure up images of Skid Row alcoholics encountered during internship days. It was found that 825 Veterans Administration psychiatrists and psychologists, in a study conducted in 1971, rejected the disease concept of alcoholism, considered treatment benefits limited, and were reluctant to participate except minimally in rendering services to alcoholics.[74]

Sterne and Pittman found that therapists with moralistic attitudes toward alcoholism were more pessimistic regarding recovery and viewed alcoholics as poorly motivated, while therapists expressing illness-oriented attitudes toward alcoholism were more optimistic.[75]

These traditional attitudes toward alcoholism which reflect punitive and moralistic sentiments are deeply rooted in Western culture, and these attitudes define what community services are available for treating alcoholics. Resistance to treating alcoholism is sometimes engendered by the alcoholic's behavior which violates the norms of the treatment personnel: "the alcoholic may be aggressive while intoxicated, too dependent when sober, financially

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[74] Eleanor Hanna, "Attitudes Toward Problem Drinkers," Journal of Studies on Alcohol 39 (1978):99.

[75] M. W. Sterne and D. J. Pittman, "The Concept of Motivation: A Source of Institutional Professional Blockage in the Treatment of Alcoholics," Quarterly Journal of Studies of Alcohol 26 (1965):48.

irresponsible, and uncooperative concerning treatment plans."[76]

There were three sources of pessimism given by Pittman and Kendis. The first was the recognition that the community is not making an adequate attempt at treatment of alcoholics. The second source is the inability to accept the chronic features of the disease. The third is the perplexity of the treatment of alcoholism.[77]

Steinglass has written about the disinterest in alcoholism on the part of family therapists, and states that they "have merely been following the predilections of their colleagues in the mental health profession."[78] He continues by indicating that professional stereotypes about alcoholism and the alcoholic have been well documented and that the alcoholic is viewed as a "distasteful, self-indulgent, weak individual involved in a pernicious cycle of self-destructive behavior . . . with low motivation to change and therapeutic work therefore felt to be unrewarding."[79] Although originally viewed as scientifically objective, these stereotypes have more recently been characterized as

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[76] David J. Pittman and Joseph B. Kendis, "The Medico-Sociologic Therapy of Alcoholism," Current Psychiatric Therapies 8 (New York: Grune and Stratton, Inc., 1968):94.

[77] Ibid.

[78] Steinglass, "Experimenting with Family Treatment," p. 118.

[79] Ibid.

culturally determined, and if applicable at all, applying only to a very small percentage of the alcoholic population. Therefore, in part, the family therapist is merely suffering from cultural prejudices.[80]

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[80] Ibid.

CHAPTER III

THEORY

The attention given to family therapy approaches in treating alcoholism has been disproportionately low in relation to the magnitude of alcohol abuse as a clinical problem and its acknowledged impact on family life. The pervasiveness of alcohol abuse and use in the United States is of such proportions as to guarantee that any mental health professional practicing in this country will be working with a significant number of patients whose use of alcohol has reached abusive proportions. For family therapists, who by definition work with groups of two or more adults in conflict either with each other or with their children, the likelihood that one member of this group abuses alcohol becomes even greater. It seems clear therefore that treatment techniques for alcoholism should be of primary concern to the family therapist. But as the review of the literature points out, although alcohol specialists have found family therapy techniques extremely useful in their work, family therapists have shown little interest in the clinical and theoretical aspects of alcoholism.

Why does this phenomenon exist? Two of the most obvious difficulties that confront a family therapist in dealing with alcoholism are lack of information about

alcoholism and anxiety about drinking. Even with the formation of the National Institute on Alcohol Abuse and Alcoholism, the average individual family therapist is still unaware of the magnitude of this disorder. The anxiety about drinking on the part of the therapist has at least two components: concern about whether the therapist or members of his family might have a drinking problem, and the difficulty the therapist has in exposing himself/herself to the intoxicated behavior of the client. Most therapists experience discomfort in the presence of intoxicated patients; the intoxicated person is viewed as excessive, sloppy, impulsive, dependent, and lacking in self-control.

One of the most difficult conflicts in working with alcoholics is the playing of complementary games. The alcoholic comes to the therapist saying, "Please help me, but I won't let you," and the therapist responds by saying, "Why won't you let me help you like my other clients do?" Alcoholism is one of the most, if not the most, difficult conditions to treat. The alcoholic and his family usually have more invested in remaining the same or defeating the therapist than they do in improving. Alcoholism by definition is a progressive disorder that can take 10 to 20 years to reach chronic proportions. This is a long period of time to develop life patterns, and improving means not only to stop drinking, but it means facing a world that the

alcoholic and family have been avoiding. Sometimes this is more threatening than drinking, so instead of improving, the alcoholic improves some and then regresses back to the previous drinking behavior. The alcoholic also pulls the therapist into his rationalization process and says to the therapist, "See, I'm really no good like everyone said, I've even let you down," and this is used as a further reason to drink.

Alcoholism has been demonstrated to exist most typically in an extremely stable and often rigid interactional context. Its behavioral characteristics seem indicative of homeostatic behavior in a steady-state system. Alcoholism is a chronic behavioral process and uses family systems to stabilize both internal interaction and relationships with the external environment. Even with this knowledge, there has been some difficulty in viewing alcoholism as a family systems problem and recommending family therapy as an appropriate course of treatment. Some reasons for this could be first in the area of the definition. Drinking behavior exists along a continuum starting with total abstinence, progressing through occasional drinking associated with social rituals, social drinking, heavy drinking, and ending with addictive drinking. Somewhere along this continuum one makes the judgment that the drinking behavior has reached abusive levels. Where to draw the line separating

pathological from customary behavior is a controversial and subjective issue.

Family therapy historically developed in response to clinical conditions manifesting symptomatology in the childhood generation, and the second issue concerns the existence of the symptom in the parental generation, i.e., the alcoholic. The key concept in the development of family therapy, the concept of the identified patient, has been traditionally applied to the situation in which a child in a family becomes symptomatic in response to a dysfunctional family system. Alcoholism in a family context represents the reverse situation, where the parent becomes periodically symptomatic as an adaptive or stabilizing mechanism for the family system.

Another issue that theoretically explains the disinterest of family therapists in treating alcoholism is the fact that alcoholics usually don't follow through with treatment. When a child is "the problem," a parent or an adult can usually get them in for treatment. If the child is a runaway or involved in a status or juvenile offense, the therapist may have cooperation with the court systems. With an alcoholic, the therapist has neither. Rarely is the alcoholic sentenced to treatment. The next most difficult family to treat is the sexual abuse family. These families usually require several years of therapy, as do

alcoholic families; but the therapist is more confident that the sexual abuse families will follow through with treatment, since protective services and usually a probation officer are involved and the family member doing the abusing must follow through or face a prison sentence. If the sexual abuser is an alcoholic, the therapist has leverage; if not, there is little to keep the family in therapy long enough to produce positive results, except for the family's own motivation.

Even though family therapists may be suffering from cultural prejudices, they pride themselves on their ability to look afresh at traditional mental health problems. How then do family therapists view alcoholism? This research is based upon the following hypotheses:

1. Family therapists are more interested in the utilization of the entire family with treating alcoholism, as opposed to treating only the alcoholic or the family separately.
2. Family therapists who have treated alcoholic families with success have less negative attitudes toward alcoholism and are more interested in treating alcoholism than therapists who have not had success or who have not treated alcoholic families.
3. Family therapists are less interested in treating alcoholism, as compared to other family disorders.

There will be no control variables used in this study, since it does not apply to this population or to this research.

CHAPTER IV

RESEARCH DESIGN AND METHODOLOGY

Introduction

The primary purpose of this study is to explore attitudes, interests, approaches, and success in treating the alcoholic family, and to test the three foregoing hypotheses.

Hypothesis 1 was based on the assumption that once a tentative diagnosis of the family system is made, the goal of the therapist is to influence the modus operandi of the family as expressed through its interaction. This is done in the hope of influencing each individual to function within the system toward optimal input and, consequently, toward fuller participation and greater satisfaction for all family members.

Hypotheses 2 and 3 were based on the chronic features of alcoholism and the perplexity of treatment. Family therapists, as other professionals, like to experience their services as productive and significant. If a therapist has worked successfully with alcoholic families, he or she would naturally be expected to have a more optimistic outlook on treating other families with alcoholic problems. As has been thoroughly documented, alcoholics have been stereotyped as not "staying cured," not following

directions, not keeping appointments, and not following through with treatment. Also, from the review of the literature, several studies indicated that alcoholics are at the bottom of the list of clients with whom therapists like to work; therapists have expressed that they would prefer being labeled "mentally ill" to being labeled "alcoholic."

Research Instrument

The instrument of research was a questionnaire. The questionnaire was mailed to all the respondents and was self-administered. This questionnaire contained 52 items and was divided into three sections. The first section was "Professional Background," including six items directed toward obtaining information and data on professions, years of experience, number of alcoholic families treated, success rate in treating these families, professional orientations, and location of practice.

The major section of the questionnaire, "Professional Opinions," was made up of 41 statements, 40 of which made up the defining items and one of which scored directly the interest of each therapist in treating the alcoholic family. The 40 items were attitude and interest statements about alcoholism, attitudes and opinions about the etiology of alcoholism, and treatment approaches, rated on a 5-part Likert scale ranging from "strongly disagree" (1) to "strongly agree" (5). The one statement scoring the family

therapist's interest in working with alcoholic families as compared to working with other family problems was scored on a Likert scale from 1 to 7: "completely disinterested" (1) to "more interested in treating alcoholic families than other families" (7).

The last section, "Personal Data," included five questions on age, sex, religious preference, state, and area of practice.

A pre-test was not conducted due to the design of the research and the homogeneous population being sampled.

Some of the methods and items used in this questionnaire are similar to methods and items used by previous investigators: Alan M. Marcus, Survey of Attitudes Toward Alcoholism (1963); and Janice F. Snider, Surveying Therapist Attitudes and Success in Treating Schizophrenia (1978).

Formulation of Questions and Assumptions

It is generally accepted that alcoholism has a major impact on families. That is to say, the misuse of alcohol by one family member has a myriad of consequences for other family members. All family members, not just the alcoholic person, experience the painful effects of the progressive destruction associated with this chronic and prevalent illness. Likewise, from a family systems approach the family structure can be predisposing to alcoholism and

has been known to perpetuate the disease. It is these interactive effects of alcohol misuse on family life that have led most professionals in the field to think of alcoholism as a family illness. However, this knowledge of the impact of alcohol misuse on families does not seem to be matched with the existence or availability of family services, or with an interest in treating the alcoholic family. From the review of the literature, the lack of family therapy for alcoholics has been directly linked to negative attitudes about treating alcoholics and to lack of interest in doing so.

Our society has many attitudes and beliefs about alcohol and alcoholism. Many definitions of alcoholism are offered in the literature. One of the most widely accepted definitions is that alcoholism is a chronic, progressive, and potentially fatal disease characterized by tolerance, physical dependence, and pathological organ changes.

Researchers are seeking to broaden society's knowledge of alcoholism and available treatment. This research project was an attempt to examine attitudes of family therapists in treating the alcoholic family. An attitude as a sociopsychological construct is a multifaceted phenomenon, often considered multidimensional, with three independent components: belief, interest, and knowledge.

The questionnaire used in this study is the outcome of extensive research of the opinions, speculations, and documentations of research conducted, research proposed, and hypotheses formulated. As a result of that research, ten areas of attitudes were isolated and were considered to represent the major dimensions of therapists' opinions, interest, knowledge, and approaches to alcoholism. Four items were selected to define each of these dimensions.

Procedure for Obtaining the Sample Population

The population surveyed are marriage and family therapists who are members of the American Association for Marriage and Family Therapy. The American Association for Marriage and Family Therapy is the professional organization for marriage and family therapists; it includes, as of 1980, over 8,000 members throughout the United States and Canada. Members include persons trained in psychology, psychiatry, counseling, social work, and pastoral counseling, all of whom are highly educated professional therapists working to help individuals and couples solve their marriage and family problems.

There are 5,344 clinical members of the American Association for Marriage and Family Therapy in the United States and Canada listed alphabetically in the 1980 Register. The sampling method employed was a systematic sample with a random start; the random number was 25, with a skip

interval of 36. A systematic sample of 150 therapists was drawn from the list of 5,344 therapists, and a questionnaire with a self-addressed stamped envelope was mailed to each of the 150 members.

A cover letter accompanied the questionnaire to explain the research study and to assure the participants of complete confidentiality.

Method of Data Analysis

The data for all the questions in Section I and Section II were recorded on a tally sheet by the researcher. The data collected under professional background was used to make correlations between the different populations, i.e., psychiatrist, psychologist, psychiatric social worker, and other, by using chi-square.

The number of successfully treated alcoholic families was compared to the number of alcoholic families treated and the interest in treating alcoholism by looking at mean scores.

Years of experience and age were analyzed by looking at the mean, median, and range, for central tendency. Location, area of practice, and religious preference were tabulated for interest, but not compared. The interest of female and male practitioners was compared by first obtaining a mean score and then using chi-square.

The data in Section II was analyzed separately. An individual could obtain a score of from 1 to 5 on each of the 40 items. The statistic which was of the most interest was the mean factor score for the total group of therapists and for individual professionals sampled. To obtain the sample score on any factor, the sum was taken on the four defining items for that factor and divided by four. The mean factor score for a group was the average of the factor score obtained by all the individuals in that group. There are three stages in the computation: (1) Compute the sum of the four defining items for each member; (2) Obtain the total of these sums for all the persons in the group; and (3) Divide this figure by the number of items, (4) times the number of persons. A cross-check was made by tabulating the scores for each of the 40 items, obtaining the frequency, multiplying the frequency by the score, calculating the sums of this, and dividing the sum by the number of responses to each statement, obtaining the mean ($\bar{x}$).

A mean score was obtained for the 41st item using the latter method of analysis.

CHAPTER V

ANALYSIS OF THE DATA

The data is based on a total sample of 54 respondents. Sixty questionnaires were returned, but only 54 were completed; the six partially completed questionnaires had to be eliminated. Seven questionnaires were returned by the postal service marked "addressee unknown," one questionnaire was returned with a letter explaining that the member was deceased as of May 1981, and one questionnaire was returned with the member having refused to complete the questionnaire.

Demographic Data

The respondents' age range was 43 (73-30) with a mean age of 46.85 years and a median age of 47 years. There were 19 female respondents and 35 male respondents.

The professional sample included three psychiatrists, 11 psychologists, 20 psychiatric social workers, 12 counselors, and eight ministers, chaplains and pastoral counselors. Their years of experience had a range of 33 (35-2), with a mean of 14.6 years and a median of 10.5 years. The number of alcoholic families seen during that period ranged from one to 500, with a mean of 103.8 and a median of 60. The proportion of families with whom therapy was viewed as successful ranged from 0 to 100 percent, with a mean of 38.19 and a median of 40.

Under the location of practice, whether it was hospital (inpatient), clinic (outpatient), private practice, or other (to be specified), it was found that the majority of therapists practiced in at least two areas and sometimes three. Seventy-seven percent of the therapists had a private practice, 31 percent practiced in outpatient clinics, and 19 percent utilized inpatient hospitalization. Under the "other" category, there were two professors teaching at universities, one welfare service employee, three researchers, six pastoral counselors working in church offices, and three employees of a family agency.

There was much more variation in the area of practice, urban or rural. Of the 54 respondents, six practiced in a rural area, 42 in an urban area, and six practiced in both an urban and a rural area.

The respondents represented all four regions of the United States; one respondent was from Toronto, Canada. Even though all regions were represented, there was a concentration of responses from the Eastern United States. Respondents were from 24 states, including South Carolina (2), Illinois (2), New York (9), Kansas (2), New Jersey (6), Texas (3), Nevada (1), California (4), Oklahoma (2), Pennsylvania (3), Florida (2), Rhode Island (1), Virginia (2), Oregon (1), Michigan (2), Wisconsin (2), North Carolina (1), Massachusetts (1), Indiana (1), Georgia (2),

Minnesota (1), Colorado (1), Idaho (1), Kentucky (1), and the District of Columbia (2).

Twelve of the respondents were Jewish and three were Catholic. Five therapists defined their religious preference as Protestant. Three were Baptist; two members were Methodist; two respondents were Presbyterian; three were Lutheran; three were Episcopalian; three were Unitarian; one was a Seventh Day Adventist; and one is a member of the Latter Day Saints. Two were atheist; one was a humanist; and 13 stated that they had no religious preference.

Influences of Approaches to Marriage and Family Therapy

The people or schools of thought that significantly influenced the therapists are listed in ascending order: Erich Fromm, Abraham Maslow, Gestalt, Jung, Adler, Whitaker and Malone (Experiential), Ackerman, Sullivan (Interpersonal), Glasser (Reality Therapy), Milton H. Erickson, Jay Haley, Murray Bowen, Salvador Minuchin, Rogers (Client-centered), Freud (Psychoanalysis), and Virginia Satir.

Many therapists listed more than one and the average preference was four. The three therapists/theorists viewed as most significant were much above the rest: Rogers (25 percent); Freud (33 percent); and Satir (42 percent).

The theorist or school of thought that was viewed as the most influential in the experience and growth of the therapist was, first, Freud (psychoanalytic), second,

Salvador Minuchin, and third, Glasser (Reality Therapy).

Presentation and Discussion of Results

Since the items used in Section II of the questionnaire are truly opinion or belief statements, there are no absolutely "right" or "wrong" answers. For this reason, the factor scores for any group may be meaningful only in comparison with some other group or in respect to criteria of the attitudes researched of all therapists responding to this questionnaire.

Table 1 shows the "label" given each factor (Column 1) and gives a brief interpretation of the significance of high and low scores on the factors (Column 3). The therapist's position analyzed as a mean factor is presented (Column 4) and is the mean score calculated from the 5-point scale. As may be seen, the responses in this research correlated very closely to speculations and information presented in the review of the literature. The professionals who have the responsibility for the treatment of alcoholics bring to the therapy relationships with the patients, attitudes toward alcohol and alcoholism. From factors 1, 4, 6, 9, and 10 as indicated by therapist position, the attitude toward treating alcoholics is moderately negative. This does not correlate especially with factor 6 (with the belief that the prognosis for recovery indicates that alcoholics do not and cannot be helped to recover from alcoholism) when the

TABLE 1

INTERPRETATION OF THE SIGNIFICANCE OF
HIGH AND LOW SCORES ON THE FACTORS

Factor	Defining Items	Interpretation	Therapists' Position *
1. The alcoholic as a dependent personality	13,25,34,41	A high score indicates the belief that the alcoholic is a dependent personality who cannot stop drinking without the help of others.	3.61
2. Etiology of alcoholism	12,22,33,38	A high score indicates the belief that alcoholism is a familial disorder and that genetic factors and psychological problems are important contributing factors in its development.	3.57
3. Alcoholism as a family problem	15,18,36,43	A low score indicates the belief that alcoholism is implicated in child neglect and abuse and that the emotional pain of alcoholism is felt by the entire family.	2.53
4. Anxiety related to treating the alcoholic family	7,17,31,42	A high score indicates the belief that therapists experience discomfort in treating the alcoholic family and may experience their services as unproductive and insignificant.	3.66

TABLE 1 (Continued)

Factor	Defining Items	Interpretation	Therapists' Position*
5. Approaches to treating the alcoholic family	8,24,32,40	A high score indicates the belief in a systems approach to treating the alcoholic family and in the alcoholic as a part of a family system.	3.87
6. Prognosis for recovery	10,20,28,37	A high score indicates the belief that most alcoholics do not, and cannot be helped to, recover from alcoholism.	3.48
7. Knowledge of alcoholism	14,19,35,44	A low score indicates deficiency in basic knowledge of alcoholism and how the family can perpetuate the alcoholic member's drinking.	2.19
8. Family systems approach to alcoholism	9,21,27,39	A high score indicates the belief that the family's emotional homeostasis can perpetuate the drinking and that if the family relationship system is modified, the alcoholic dysfunction can possibly be alleviated.	3.87

TABLE 1 (Continued)

Factor	Defining Items	Interpretation	Therapists' Position*
9. Therapeutic work with alcoholics as being unrewarding	16,26,30,46	A high score indicates the belief that alcoholism is a difficult illness to treat. A high score also indicates the belief that the therapist may experience pessimism about any long-lasting positive results of therapeutic intervention and work and that such effort is therefore felt to be unrewarding.	3.21
10. Family therapist personal drinking patterns and family members' drinking problems as a source of anxiety in treating the alcoholic family	11,23,29,45	A high score indicates the belief that the family therapist can be affected by experiencing anxiety while treating the alcoholic if the therapist has a drinking problem or has a family member with a drinking problem. A high score also indicates that the therapist would rather be labeled "mentally ill" as opposed to "alcoholic."	3.64

* Range 1 - 5; low score 1 - 2.5; high score 2.5 - 5.

successfully treated family is considered, but does correlate with the review of the literature.

As stated in the demographic data section, the proportion of families with whom therapy was viewed as successful was a mean of 38.19 and a median of 40. As stated by the National Institute on Alcohol Abuse and Alcoholism, no regression back to alcohol and complete recovery rate of alcoholism was only 30 percent.[1] Therefore, the negative attitudes have not significantly affected the success rate. Another factor to be considered in the high correlation from factors 2, 3, 5, and 8 is the belief that alcoholism is a family problem, and the treatment approach to alcoholism is from systems theory. This would indicate that alcoholic families are therefore treated together, and the high success rate could be attributed to this treatment modality.

In factors 4 and 10, there is an indication that therapists experience discomfort in treating the alcoholic family and experience anxiety in the presence of the intoxicated client. Also, there is strong indication that a therapist's own drinking behavior or family member's drinking behavior can cause anxiety with treating the alcoholic family.

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[1] "Someone Close Drinks Too Much," National Institute on Alcohol Abuse and Alcoholism, Department of Health, Education and Welfare (1980), p. 14.

Table 2 presents the mean factor scores for five samples. The most practical use of this table is to compare these groups to the criterion group and to see how similar each given group's positions are. As can be seen, there is a high agreement of professional consensus. It could be assumed that personal issues contributed to the similarity in the cross-section. Professionals with different backgrounds and with different educations would possibly present more diversity in responses. It could also be questioned as to whether the Association attracts people who view alcoholism similarly, or whether a therapist with such views seeks out this Association.

Statement 47 in Section II surveyed the interest family therapists had in working with alcoholic families as compared to working with other family problems, and was scored on a Likert Scale from 1 to 7: "Completely disinterested" (1); and "More interested in treating alcoholic families than other families" (7). Chi-square was used to compare the interest of the three professional groups: M.D.'s and Ph.D.'s, social workers, and counselors/ministers (Table 3) and of male and female practitioners (Table 4). There was no statistically significant evidence to indicate that there was a difference in the interest or disinterest in the population.

TABLE 2

MEAN FACTOR SCORES FOR THE FIVE POPULATIONS

	Psych. Soc. Worker N=20 M-9 F-11	Psychol. N=11 M-10 F-1	Couns. N=12 M-5 F-7	Min., Past. Couns. N=8 M-8 F-0	Psychiat. N=3 M-3 F-0
1. Alcoholic, a dependent personality	3.74	3.49	3.37	3.63	3.67
2. Etiology of alcoholism	3.61	3.63	3.53	3.35	3.67
3. Alcoholism, a family problem	2.35	2.24	2.72	2.75	2.42
4. Anxiety in treating alcoholic family	3.60	3.88	3.64	3.50	4.00
5. Approaches to treating the alcoholic family	4.02	3.59	3.78	3.88	4.25
6. Prognosis for recovery	3.57	3.43	3.66	3.57	3.17
7. Knowledge of alcoholism	2.39	2.28	2.93	1.82	2.42
8. Family systems approach to alcoholism	3.81	3.79	3.98	3.56	3.75
9. Therapeutic work unrewarding	3.25	2.98	3.50	2.94	3.50
10. Therapist's personal contribution to anxiety	3.52	3.84	3.76	3.69	3.92

TABLE 3

INTEREST IN TREATING ALCOHOLIC FAMILIES BY PROFESSION

Interest in Treating Alcoholic Families	M.D. Ph.D.	Social Worker	Counselor Minister
Disinterested	5	9	4
Neutral	1	3	4
Interested	8	8	12
	14	20	20

Obtained $x^2 = 4.37$, table $x^2 = 9.488$.
No significant difference at the .05 confidence level with 4 degrees of freedom

TABLE 4

INTEREST IN TREATING ALCOHOLICS BY SEX

Interest in Treating Alcoholics	Female	Male
Interested	10	18
Not Interested	9	17
	19	35

Obtained $x^2 = 0.0075$, table $x^2 = 3.84$.
No significant difference at the .05 confidence level with 1 degree of freedom.

Table 5 shows the years of experience divided into four groups and the interest of each group as indicated by a mean score. As can be seen, the group with the least number of years of experience has the highest interest.

TABLE 5

INTEREST IN TREATING ALCOHOLICS
BY YEARS OF EXPERIENCE

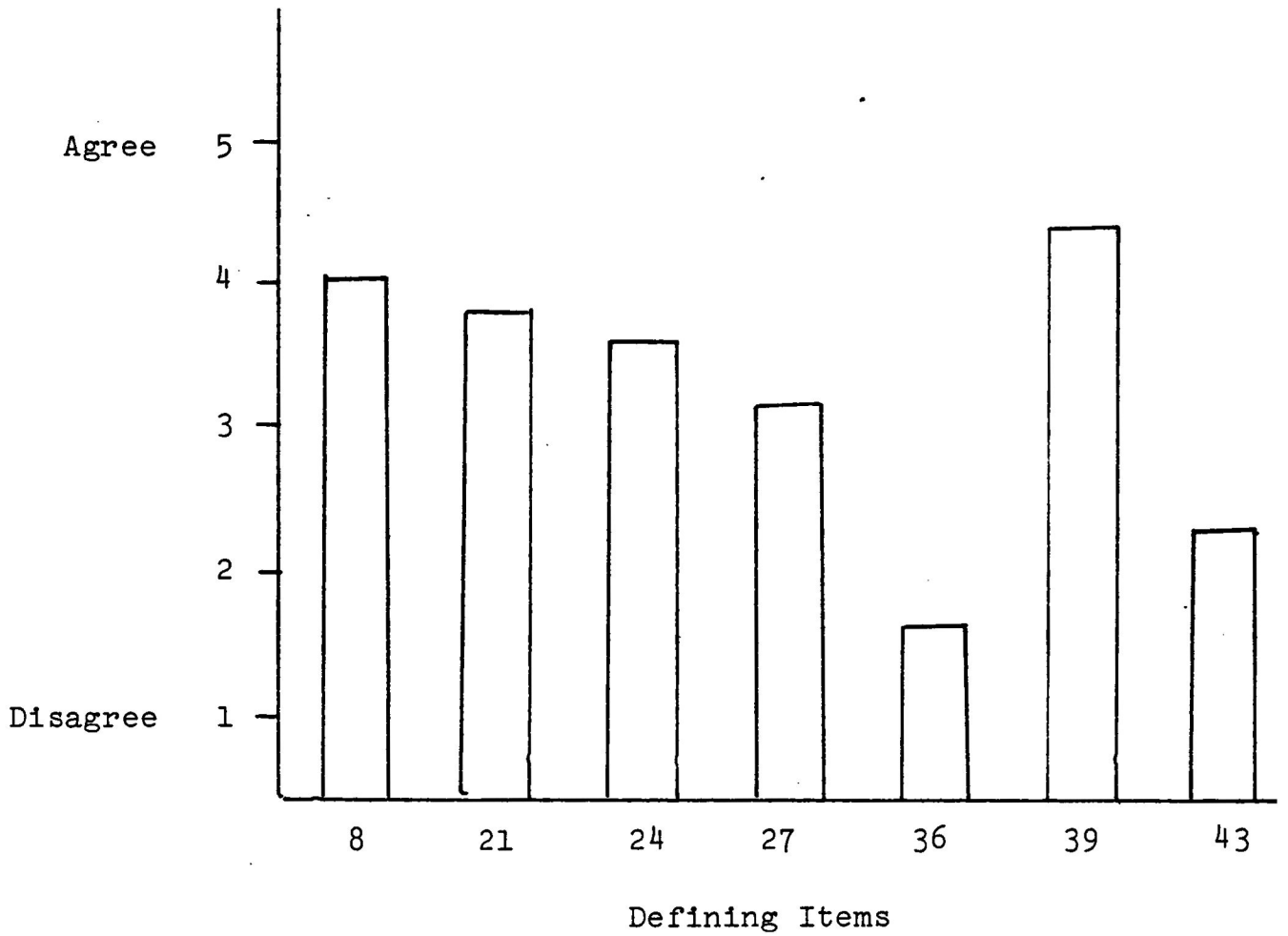
Years of Experience		Interest
1)	39 - 30	4.75
2)	29 - 20	3.57
3)	19 - 10	4.64
4)	9 - 0	5.20

Hypothesis 1: Family therapists are more interested in the utilization of the entire family with treating alcoholism as opposed to treating only the alcoholic or the family separately.

This hypothesis was confirmed by analyzing seven defining items from Section II. A low score in items 36 and 43 and a high score in items 8, 21, 24, 27 and 39 indicated a belief in the utilization of the entire family in treating alcoholism, as seen in Figure 1.

FIGURE 1

INTEREST IN THE UTILIZATION OF
ENTIRE FAMILY IN THE
TREATMENT OF ALCOHOLISM



Hypothesis 2: Family therapists who have treated alcoholic families with success have less negative attitudes toward alcoholism and are more interested in treating alcoholism than therapists who have not had success with or who have not treated alcoholic families.

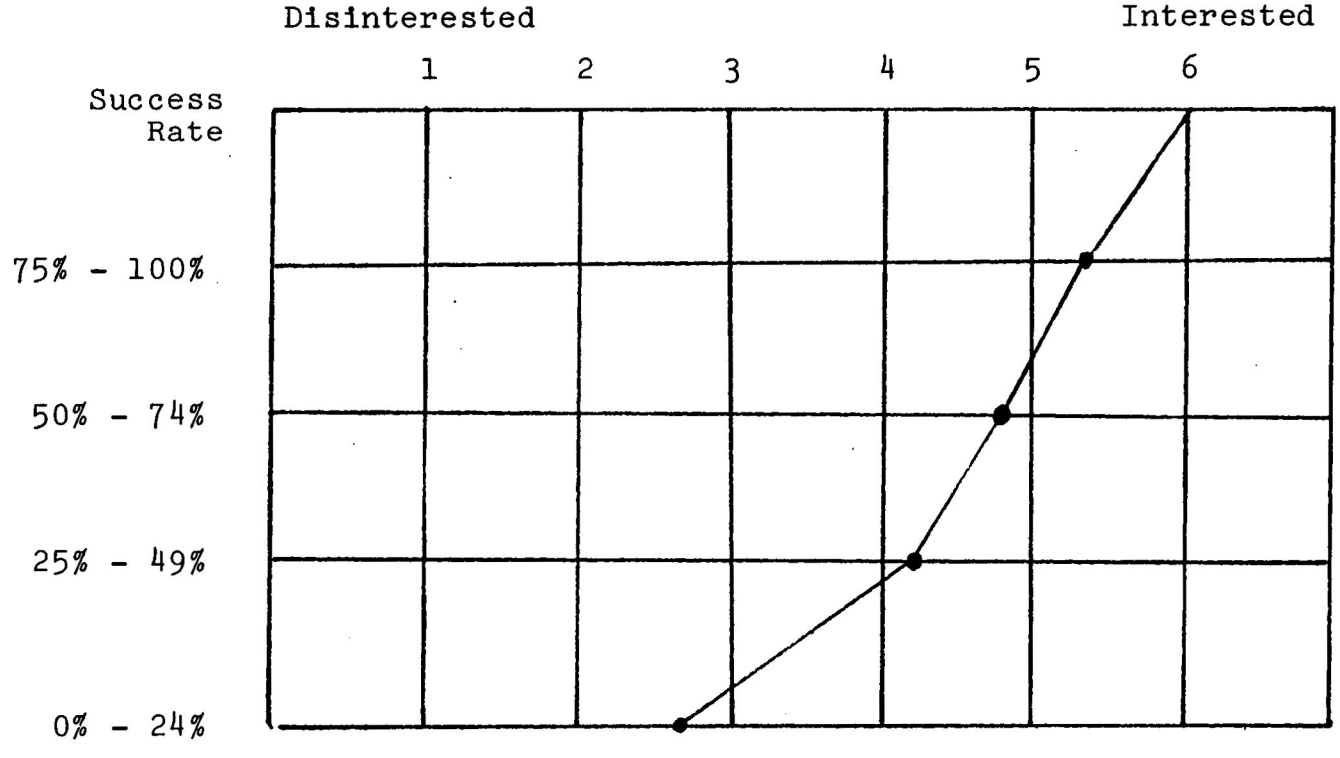
The results confirmed this hypothesis directly, as can be seen in Figure 2. The success rate was divided into four groups (75 to 100 percent, 50 to 74 percent, 25 to 49 percent, and 0 to 24 percent). The interest tabulation is the mean score analyzed from statement 47 of the questionnaire. The results indicate that the interest is directly related to the success rate or vice versa. This does not, however, indicate that the attitude toward treating alcoholism is directly proportional. Since there was consensus of all the groups, as seen in Tables 1 and 2, tabulating the attitudes seemed redundant, and would probably also indicate consensus.

Hypothesis 3: Family therapists are less interested in treating alcoholism as compared to treating other family problems.

The confirmation or non-confirmation of this hypothesis was taken directly from statement 47 of the questionnaire: "As compared to other family therapy situations (i.e., blended family conflict, physical abuse family, family with a schizophrenic member, single-parent family

FIGURE 2

INTEREST VERSUS DISINTEREST AS
RELATED TO SUCCESS IN TREATING ALCOHOLISM



issues, marital conflict) how do you rate your interest in treating the alcoholic family on this scale?" The scale went from 1 ("completely disinterested") to 7 ("more interested in treating the alcoholic family than other families"). The mean score of the 54 respondents was 4.43, neutral. Therefore this hypothesis could neither be confirmed nor rejected.

CHAPTER VI

CONCLUSIONS AND IMPLICATIONS

The primary purpose of this thesis was to review alcoholism, the effects alcoholism has on the family, and family therapy with alcoholic families, and to explore the attitudes of family therapists toward treating alcoholic families. Also, the purpose was to test three hypotheses.

Alcoholism has always been one of the most difficult of all emotional dysfunctions to modify, regardless of the therapeutic method. Family therapy is one approach which offers promise to the alcoholic man or woman who still lives within a family setting or who shows desire for rehabilitation back into the family. However, familial approaches are not a panacea for all alcoholic problems. Nor can it be concluded that the "cause" of drinking is the family. The etiology of alcoholism remains unknown. To intervene by psychological means such as family therapy is not to deny the possibility of genetic, biochemical, neurological, cultural, and social factors.

The family systems approach was researched in this study, and the data indicate that family therapists agree that alcoholism is a family problem and that the entire family should be involved in the treatment.

Family systems therapy offers no magic solution to the total problem, but the theory does provide a different way to conceptualize the problem, and the therapy provides a number of approaches to the alcoholism problem that are not available with conventional theory and therapy. The results from this research indicated that family systems therapy is a highly effective approach to the problem of alcoholism; and the potential for treating more alcoholic families and preventing alcoholism through family systems therapy techniques is encouraging. Even with the negative attitudes toward the alcoholic as a dependent personality, prognosis for recovery as being poor, and work with alcoholics as unrewarding, the success rate was above national reports. As the study indicated, adequate knowledge, cognitive training, and attitudes toward alcoholism need to be modified. Also, the anxiety of the therapist and the therapist's own drinking patterns or family members' drinking problems contribute to the possible negative attitudes and lack of success.

There was high agreement among the different professional groups. This is thought to be partially due to the homogeneous population surveyed, all being family therapists, members of the American Association for Marriage and Family Therapy, and having met the same criteria for membership. It would seem therefore that innovation in the field would come from outside the Association and that

new opinions might not be readily accepted. The agreement which is in keeping with the mainstream thought and establishment might also be implications of the small sample. It would seem that the small sample was a major weakness and that there could have been more statistical significance if the sample had been larger.

Recommendations

Many curricula of marriage and family therapy deal with alcoholism to some degree. Cognitive training which simply imparts facts about alcoholism may not be sufficient to strengthen positive attitudes, and cognitive training may be inversely related to attitudes. Part of the implications of this study was to reflect attitudes and the need for attitudinal changes. It would seem possible and applicable, since Hypotheses 1 and 2 were confirmed, to hierarchically order cognitive goals and design educational objectives to meet criteria of educational programs and to define objectives and methods to teach desired outcomes.

Also, since a major problem of the study was the small sample, it would seem interesting and relevant to repeat the study with a larger population. With a larger population, more difference would be expected in the sample.

BIBLIOGRAPHY

Ablon, Joan. "The Significance of Cultural Patterning for the Alcoholic Family." Family Process 19 (June 1980):127-131.

"Alcoholism and the Family: Putting the Pieces Together." Alcoholism: The National Magazine 1 (January/February 1981):19-24.

Berenson, David. "Alcohol and the Family System." In Family Therapy Theory and Practice. New York: Gardner Press, Inc., 1976, pp. 284-297.

Berger-Gross, Victoria and Lisman, Stephen. "Attitudes of Paraprofessionals Toward Alcoholism: Setting Effects." Journal of Studies on Alcohol 40 (1979): 514-518.

Black, Claudia. "Innocent Bystanders at Risk: The Children of Alcoholics." Alcoholism 1 (January/February 1981):20-26.

Bowen, Murray. "Alcoholism and the Family." In Family Therapy in Clinical Practice. New York: Jason Aronson, Inc., 1978, pp. 259-268.

Bowen, Murray. "Alcoholism as Viewed Through Family Systems Theory and Family Psychotherapy." Annals of New York Academy of Sciences 233 (1974):115-122.

Byles, John A. "Violence, Alcohol Problems and Other Problems in Disintegrating Families." Journal of Studies on Alcohol 39 (1978):551-553.

Cadogan, Donald A. "Marital Group Therapy in Alcoholism Treatment." In Family Therapy of Drug and Alcohol Abuse. New York: Garden Press, 1979, pp. 191-201.

Chappel, John N. "Physicians' Attitudes and the Treatment of Alcohol and Drug Dependent Patients." Journal of Psychedelic Drugs 10 (January/March, 1978):27-33.

Cooke, G., Gerald, W., and Gruber, J. "Training Paraprofessionals in the Treatment of Alcoholism." Journal of Studies on Alcohol 36 (1975):938-947.

Corrigan, Gilbert E. "The Fetal Alcohol Syndrome." Texas Medicine 72 (January 1976):72-74.

Cotton, Nancy S. "The Familial Incidence of Alcoholism." Journal of Studies on Alcohol 40 (1979):89-117.

Davis, P., Stern, D. R., and Vardeuser, J. M. "Enmeshment-Disengagement in the Alcoholic Family." Currents in Alcoholism: Psychiatric, Psychological, Social, and Epidemiological Studies, 8. New York: Grune and Stratton, Inc., 1978, pp. 15-24.

Dinsburg, D., Glick, I. D., and Feigenbaum, E. "Marital Therapy of Women Alcoholics." Journal of Studies on Alcohol 38 (1977).

Estes, Nada J. "Counseling the Wife of an Alcoholic Spouse." American Journal of Nursing 74 (July 1974): 1251-1255.

Ewing, John A. and Fox, Ronald E. "Family Therapy of Alcoholism." Current Psychiatric Therapies, 8. New York: Grune and Stratton, Inc., 1968, pp. 86-91.

Finlay, Donald G. "Anxiety and the Alcoholic." Social Work 17 (November 1972):29-33.

Finlay, Donald G. "Alcoholism and Systems Theory: Building a Better Mousetrap." Psychiatry 41 (August 1978): 272-277.

Fisher, J. C., Mason, R. L., Keeley, K. A., and Fisher, J. V. "Physicians and Alcoholics." Journal of Studies on Alcohol 36 (1975):949-955.

Foley, Vincent D. "Alcoholism: A Family System Approach." Journal of Family Counseling 4 (December 1976):12-18.

Fox, Ruth. "The Effects of Alcoholism on Children." National Council on Alcoholism, 1972.

Freeman, David S. "The Use of Time in Family Therapy." Family Therapy 4 (1977):195-206.

Gurel, M. and Spain, M. D. "Differences in Attitudes Toward Alcoholism in Graduates of Two Schools of Nursing." Psychological Reports 41 (1977):1285-1286.

Hanna, Eleanor. "Attitudes Toward Problem Drinkers." Journal of Studies on Alcohol 39 (1978):98-107.

Hayman, Max. Alcoholism. Illinois: Charles C. Thomas, 1966, pp. 226-232.

Herjanic, B. M., Herjanic, M., Perick, E. C., Tomelleri, C. J., and Armbruster, R. B. S. "Children of Alcoholics." Currents in Alcoholism: Psychiatric, Psychological, Social and Epidemiological Studies, 2. New York: Grune and Stratton, Inc., 1977, pp. 445-453.

Hindman, Margaret. "Children of Alcoholic Parents." Alcohol Health and Research World (Winter 1975/76), pp. 2-6.

Hoy, Richard M. "Beliefs About Alcoholism." British Journal of Medical Psychology 50 (1977):227-235.

Jacob, T., Favorini, A., Meisel, S. S., and Anderson, C. M. "The Alcoholic's Spouse, Children and Family Interactions." Journal of Studies on Alcohol 39 (1978): 1231-1242.

Jackson, Joan K. "The Adjustment of the Family to the Crisis of Alcoholism." Quarterly Journal of Studies on Alcohol 15 (December 1954):562-586.

Janzen, Curtis. "Family Treatment for Alcoholism: A Review." Social Work 23 (March 1978):135-141.

Kenward, Kevin and Rissover, Jean. "A Family Systems Approach to the Treatment and Prevention of Alcoholism: A Review." Family Therapy 7 (1980):97-105.

Kilty, Keith M. "Attitudes Toward Alcohol and Alcoholism Among Professionals and Nonprofessionals." Journal of Studies on Alcohol 36 (1975):327-365.

Know, W. J. "Attitudes of Psychiatrists and Psychologists Toward Alcoholism." American Journal of Psychiatry 127 (November 1971):1676-1678.

Loepscheider, Sharon. "From the Family Trap to Family Freedom." Alcoholism (January/February 1981), pp. 36-40.

Luke, Barbara. "Maternal Alcoholism and Fetal Alcohol Syndrome." American Journal of Nursing 77 (December 1977):1924-1926.

Mayer, Joseph and Black, Rebecca. "The Relationship Between Alcoholism and Child Abuse and Neglect." Currents in Alcoholism: Psychiatric, Psychological, Social and Epidemiological Studies, 2. New York: Grune and Stratton, Inc., 1977, pp. 429-451.

McCord, Joan. "Etiological Factors in Alcoholism." Quarterly Journal of Studies of Alcohol 33 (1972):1020-1027.

McKamy, Ray L. "Multiple Family Therapy or an Alcohol Treatment Unit." Family Therapy 3 (1976):197-207.

Meeks, D. E. and Kelly, C. "Family Therapy with the Families of Recovering Alcoholics." Quarterly Journal of Studies on Alcohol 31 (1970):399-408.

Minuchin, Salvador. Families and Family Therapy. Massachusetts: Harvard University Press, 1974.

Muella, John F. "Casework with the Family of the Alcoholic." Social Work (September 1972), pp. 79-85.

Mulvihill, J. J., Klimas, J. T., Stokes, D. C. and Risenbert, H. N. "Fetal Alcohol Syndrome: Seven New Cases." American Journal of Obstetrics and Gynecology 125 (August 1976):937-941.

Paolino, Thomas J. and McCrady, Barbara S. "Systems Theory Approaches to the Alcoholic Marriage." In The Alcoholic Marriage. New York: Grune and Stratton, Inc., 1977, pp. 110-141.

Pittman, David J. and Kendis, Joseph B. "The Medico-Sociologic Therapy of Alcoholism." Current Psychiatric Therapies, 8. New York: Grune and Stratton, 1968, pp. 92-99.

Randall, Carrie L. "Fetal Alcohol Syndrome." Currents in Alcoholism: Biomedical Issues and Clinical Effects of Alcoholism, 5. New York: Grune and Stratton, Inc., 1979, pp. 119-121.

Satir, Virginia. Conjoint Family Therapy. California; Science and Behavior Books, Inc., 1967.

Shapiro, Rodney J. "A Family Therapy Approach to Alcoholism." Journal of Marriage and Family Counseling (October 1977), pp. 71-79.

Smoyak, Shirley. "Therapeutic Approaches to Alcoholism Based on Systems Theories." Occupational Health Nursing 21 (April 1973):27-30.

Steiner, Claude. Games Alcoholics Play. New York: Ballantine Books, 1971.

"Someone Close Drinks Too Much." National Institute on Alcohol Abuse and Alcoholism, Department of Health, Education and Welfare, 1980.

Steinglass, Peter. "Experimenting with Family Treatment Approaches to Alcoholism, 1950-1975: A Review." Family Process 15 (March 1976):97-121.

Steinglass, Peter. "Family Therapy with Alcoholics." In Family Therapy of Drug and Alcohol Abuse. New York: Garden Press, 1979.

Steinglass, Peter. "A Life History Model of the Alcoholic Family." Family Process 19 (1980):211-227.

Steinglass, P., Davis, D. I., and Berenson, D. "Observation of Confointly Hospitalized Alcoholic Couples During Sobriety and Intoxication: Implications for Theory and Therapy." Family Process 46 (March 1977): 1-16.

Sterne, M. S. and Pittman, D. J. "The Concept of Motivation: A Source of Institutional Professional Blockage in the Treatment of Alcoholism." The Quarterly Journal of Studies of Alcohol 26 (1965):46-50.

"Understanding Alcoholism." Alateen, Hope for Children of Alcoholics. New York: Al-Anon Family Group Headquarters, Inc., 1973, pp. 3-9.

U. S. Department of Health, Education and Welfare, National Institute on Alcohol Abuse and Alcoholism. "Alcohol and Your Unborn Baby." Washington, D. C.: Government Printing Office, 1978.

Waring, Mary L. "The Impact of Specialized Training in Alcoholism on Management-Level Professionals." Journal of Studies on Alcohol 36 (1975):406-413.

Watts, F. and Bowen, B. Conjoint Family Counseling for Substance Abuse Counselors 3 (1978).

Wegsheider, Sharon. "From the Family Trap to Family Freedom." Alcoholism (January/February 1981): 36-39.

Wilson, C. and Orford, J. "Children of Alcoholism." Journal of Studies on Alcohol 39 (1978):121-133.

APPENDIX A

COVER LETTER

Dear Members of the American Association for Marriage and Family Therapy:

Atlanta University is conducting research on interests and attitudes of family therapists towards working with the alcoholic family. Your name was selected from the American Association for Marriage and Family Therapy directory.

The questionnaire solicits your opinions on alcoholism, the positive and/or negative results of family therapy with the alcoholic family, and your experience in treating the alcoholic family.

The information obtained through this research project will broaden our understanding of the nature of alcoholism and the role of the family therapist in treating the alcoholic family. It will also be useful here at Atlanta University to help strengthen the curriculum regarding the training of clinical therapists.

You may be assured of complete confidentiality. The questionnaire has an identification number for mailing purposes only. This is so that we may check your name off the mailing list when your questionnaire is returned. Your name will never be on the questionnaire.

Please complete the questionnaire and return it to me in the enclosed stamped and addressed envelope.

I am grateful for your participation and will be happy to answer any questions you might have. Please write or call me. The telephone number is (404) 881-8344, The Bridge Family Center.

Sincerely,

Nancy Copelan-Aldridge
Atlanta University
Atlanta, Georgia

APPENDIX B

QUESTIONNAIRE

I.D. NUMBER _____

THERAPIST QUESTIONNAIRE

Professional Background

1. Profession:
   1. _____ Psychiatrist
   2. _____ Psychologist
   3. _____ Psychiatric Social Worker
   4. _____ Other (specify) _____
2. How many years of experience do you have as a marriage and family therapist? _____ years.
3. During that time, approximately how many alcoholic families have you seen?
4. In what proportion of these families do you feel therapy has been successful?
5. Which of the following people or schools of thought have significantly influenced your approach to marriage and family therapy? (Check as many as apply)
   1. _____ Freud - Psychoanalysis
   2. _____ Sullivan - Interpersonal
   3. _____ Adler
   4. _____ Ackerman
   5. _____ Jung
   6. _____ Rogers - Client Centered
   7. _____ Milton H. Erickson
   8. _____ Whitaker and Malone - Experiential
   9. _____ Jay Haley
   10. _____ Murray Bowen

11. _____ Salvadore Minuchin

12. _____ Virginia Satir

13. _____ Glasser - Reality Therapy

14. _____ Other (specify) _____

If you have checked more than one of the above, please circle the one you felt was the most influential in your experience and growth as a Therapist.

6. Where do you practice? (Check as many as apply)

1. _____ hospital (in patient)

2. _____ clinic (out patient)

3. _____ private practice

4. _____ other (specify)

Professional Opinions

This section contains a number of statements about alcoholism. I want to know how much you agree or disagree with each of the statements. Below each statement you will find a rating scale: 1 2 3 4 5. The points along the scale are to be interpreted as follows:

1 Strongly disagree

2 Disagree

3 Neutral

4 Agree

5 Strongly Agree

Please circle the number that corresponds to your feelings. Please respond to each statement.

7. The alcoholic's behavior can violate the norms of the treatment personnel by being aggressive while intoxicated, too dependent when sober and financially irresponsible.

1 2 3 4 5

8. Family systems concept is based on the principle that a therapist can treat a person in an office, hospital, half-way facility, etc., but that the individual is part of a family unit.

1 2 3 4 5

9. Systems theory suggests that all family systems operate to maintain a certain level of equilibrium which is intended to minimize the threats of disruption and pain.

1 2 3 4 5

10. The alcoholic drinks excessively but often he/she does not enjoy drinking.

1 2 3 4 5

11. Some anxiety in treating the alcoholic can come from whether the therapist or member of the therapist's family have a drinking problem.

1 2 3 4 5

12. If one parent is an alcoholic, there is a six times greater chance that the children will have alcohol problems.

1 2 3 4 5

13. The alcoholic may be defiantly dependent, reaching out to the family for help with the right hand while defensively rejecting all help with the left

1 2 3 4 5

14. Most persons who use beverage alcohol usually harm themselves and others.

1 2 3 4 5

15. Alcoholism is rarely implicated in the reported cases of child abuse and neglect.

1 2 3 4 5

16. Many therapists are pessimistic about the outcome of treat0 ing alcoholics therefore causing self-fulfilling prophecy effects.

1 2 3 4 5

17. Most therapists experience discomfort in the presence of intoxicated patients.

1 2 3 4 5

18. Fetal Alcohol Syndrome occurs only when the mother drinks during the first trimester of pregnancy.

1 2 3 4 5

19. Alcoholism affects the entire family but rarely does the family contribute to that behavior and perpetuate the alcoholic.

1 2 3 4 5

20. The alcoholic is often helped by medical and/or psychological treatment.

1 2 3 4 5

21. The family's emotional homeostasis seems to perpetuate the drinking and it is this behavior which must be changed if the drinking is to be controlled.

1 2 3 4 5

22. Alcoholism is a familial disorder, including both environmental and psychological influences and genetic factors.

1 2 3 4 5

23. Family therapists would rather be labeled themselves as "mentally ill" to being labeled "alcoholic."

1 2 3 4 5

24. In therapy for alcoholism, the target for changes is the whole system and not the individual.

1 2 3 4 5

25. The alcoholic is an orally dependent person and one who uses alcohol as a symbolic way of communicating.

1 2 3 4 5

26. The alcoholic is viewed as hopeless, unmotivated and hard to reach.

1 2 3 4 5

27. When it is possible to modify the family relationship system, the alcoholic dysfunction is alleviated, even though the dysfunctional one may not have been part of the therapy.

1 2 3 4 5

28. Most alcoholics could be rehabilitated if more help were available to them.

1 2 3 4 5

29. If you as a family therapist have a drinking problem, this could adversely affect your objectivity with treating the alcoholic family.

1 2 3 4 5

30. Working with alcoholic families can be timely, frustrating, and with no lasting results.

1 2 3 4 5

31. Alcoholism is a chronic behavioral process and the treatment is complex, therefore the therapist working with the alcoholic may experience his/her services as nonproductive and insignificant.

1 2 3 4 5

32. In treating alcoholism, falling into cause and effect thinking can be a problem.

1 2 3 4 5

33. An alcoholic's basic troubles were with him/her long before he/she had a problem with alcohol.

1 2 3 4 5

34. The alcoholic, even when not drinking, tends to be more dependent upon others than the non-drinker.

1 2 3 4 5

35. The drinking spouse usually suffers more than the non-drinking spouse.

1 2 3 4 5

36. Family systems theory holds as a basic principle that emotional pain or dysfunctioning can not be felt by the entire family.

1 2 3 4 5

37. Many alcoholics are very concerned about their problems.

1 2 3 4 5

38. Very few alcoholics come from families in which both parents were abstainers.

1 2 3 4 5

39. In treating the alcoholic family, the primary focus is not to one individual dysfunction but upon the interplay of the family dysfunctions.

1 2 3 4 5

40. The main leverage in a system where one spouse drinks excessively is the non-drinking spouse.

1 2 3 4 5

41. Even if an alcoholic has a sincere desire to stop drinking, he cannot possibly do so without help from others.

1 2 3 4 5

42. Treating the alcoholic family can be nonproductive when the alcoholic member attends sessions intoxicated.

1 2 3 4 5

43. As the alcoholic becomes acute, each member of the family begins to repress their feelings and react to survive in the situation.

1 2 3 4 5

44. The body eliminates alcohol through oxidation, and cold showers and coffee speed up oxidation.

1 2 3 4 5

45. Having a family member in your family that is an alcoholic could increase your understanding and therefore effectiveness in treating other alcoholic families.

1 2 3 4 5

46. The alcoholic is a weak individual involved in a pernicious cycle of self-destructive behavior and with low motivation to change.

1 2 3 4 5

47. As compared to other family therapy situations (i.e., blended family conflict, physical abuse family, family with a schizophrenic member, single-parent family issues, marital conflict) how do you rate your interest in treating the alcoholic family on this scale. (Check one)

_____ 1. Completely disinterested

_____ 2. Mostly disinterested

_____ 3. Disinterested, more than interested

_____ 4. Neutral

_____ 5. Interested more than disinterested

_____ 6. Mostly interested

_____ 7. More interested in treating alcoholic families than other families.

Personal Data

48. Age: _____ years

49. Sex: _____ female _____ male

50. Religious preference (specify) _____

51. In which state do you practice? (specify) _____

52. In which area do you practice?

    1. _____ rural

    2. _____ urban